



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DOCTOR'S HOSPITAL AT RENAISSANCE
5501 S MCCOLL RD
EDINBURG TX 78539

Respondent Name

McAllen ISD

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-13-0036-01

MFDR Date Received

September 7, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Outpatient"

Amount in Dispute: \$1,359.18

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Requestor's DWC-60 is stamped as received by the Division on September 7, 2012. A provider must request medical dispute resolution on a fee issue or a retrospective medical necessity review within one year of the date of service."

Response Submitted by: Flahive Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 18, 2011	Outpatient Hospital Services	\$1,359.18	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
- The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated March 7, 2011

- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
- W1 – Workers Compensation State Fee Schedule Adjustment
- 59 – Processed based on multiple or concurrent procedure rules.

Explanation of benefits dated July 1, 2011

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 18 – Duplicate claim/service
- B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment. Previously processed for recommendation

Issue

1. Did the requestor waive the right to medical fee dispute resolution?

Findings

28 Texas Administrative Code §133.307(c)(1) states: "Timeliness. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. (A) A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The date of the services in dispute is February 18, 2011. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on September 7, 2012. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307, subparagraph (B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

The Division finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute. For that reason, the merits of the issues raised by both parties to this dispute have not been addressed.

Authorized Signature

_____ Signature	_____ Medical Fee Dispute Resolution Officer	_____ May 1, 2014 Date
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YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812